IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

FRANK KENNETH MILLER, JR.,

Plaintiff,

v.

CIVIL ACTION NO. 2:18-cv-00269
Judge: Johnston

COBRA ENTERPRISES OF UTAH, INC. d/b/a Cobra Firearms, a Utah corporation; and RK HOLDINGS LLP d/b/a RURAL KING HOLDINGS, LLP, an Illinois limited liability partnership authorized to do business in the State of West Virginia,

Defendants.

AFFIDAVIT OF FRANK KENNETH MILLER

STATE OF WEST VIRGINIA

COUNTY OF KANAWHA, to-wit:

I, Frank Kenneth Miller, being over the age of 18, of sound mind, and having been duly sworn, say the following is true and correct:

1. I hereby certify that I have reviewed each and every medical bill attached hereto.

2. I hereby certify that the attached medical bills are true and complete copies of all medical bills I have incurred as of May 10, 2019, are a direct and proximate result of the injuries I suffered on June 25, 2017.

3. I hereby certify that the sum certain for the medical bills attached hereto totals $139,756.29.

4. I hereby certify that each and every medical bill attached hereto was reasonable and necessary for the medical treatment I received as a direct proximate result of the injuries I suffered on June 25, 2017.

5. I hereby certify that the medical bills attached hereto represent the medical bills I incurred only as it relates to the injuries I suffered on June 25, 2017, and for no other reason and/or injuries.

FURTHER, THE AFFIANT SAITH NAUGHT.

FRANK KENNETH MILLER

TAKEN, SUBSCRIBED and SWORN TO before me this 10 day of May, 2019.

My Commission Expires: Sep. 4, 2022.

NOTARY PUBLIC – STATE OF WEST VIRGINIA

NOTARY PUBLIC OFFICIAL SEAL
Tanya R Thomas
State of West Virginia
My Commission Expires
September 04, 2022
Bucci Bailey & Javins
213 Hale Street
Charleston, WV 25301

{SEAL}

Frank "Kenny" Miller, Jr.

Date	Provider	Description	Bill Amount
06/25/17	Boone Co Ambulance	Transport	$ 1,004.00
06/25/17	Air Evac Lifeteam	Transport	$ 31,179.16
06/25-07/19/17	CAMC	Inpatient Admission 6/25-7/3/17	$ 77,150.13
		Trauma Evaluation 6/25/17	$ 429.00
		Trauma Procedure 6/25/17	$ 2,106.00
		Pathology 6/26/17	$ 1,170.00
		ECG Report 6/26/17	$ 34.00
		CV VAS Arterial (lower left) 6/26/17	$ 83.00
		Trauma Outpatient Visit 7/12/17	$ 109.00
		Trauma Outpatient Visit 7/19/17	$ 109.00
06/25-26/17	WVU Physicians of Charleston	Part Removal Colon w Anastomosis Mobilize Splenic Flex Resect Small Intest Singl Resec/Anas	$ 7,839.00
06/25/17	General Anesthesia	Anesthesia-Removal of Small Intestine	$ 2,040.00
		Insertion Catheter Artery	$ 225.00
06/25-27/17	Associated Radiologists, Inc.	Radiology Chest PA 1 V, Lumbar Spine 2-3V, CTA Lower Extremity w-w/o 6/25/17	$ 516.00
		Radiology Chest PA 1 V 6/27/17 & 6/30/17	$ 80.00
12/13/17-5/9/18	Boone Memorial Hospital	Therapies	$ 13,361.00
11/26/18	Dr. Darshan Dave	Office visit and nerve conduction study	$ 1,352.70
1/18-2/11/19	MedCare Therapy Center	Therapies	$ 970.00
SUBTOTAL	**$ 139,756.29**		

TOTAL DUE	$0.00

Boone County Ambulance Authority
836 4TH AVE
HUNTINGTON, WV 25701-9998

ITEMIZED INVOICE

FRANK MILLER
9964 DANIEL BOONE PKWY
Foster, WV 25081

Boone County Ambulance Authority
836 4TH AVE
HUNTINGTON, WV 25701-9998
866-659-9113

TO ASSURE PROPER CREDIT, RETURN THIS PORTION WITH YOUR PAYMENT
Ticket # : BQ170625-2233-BCA:1

Statement Date	Patient ID	AMOUNT PAID
05/09/19	863793	

DETACH HERE

MAKE CHECKS PAYABLE TO: Boone County Ambulance Authority

BALANCE	$0.00

Date of Service	Description	Patient Name	Charge(s)	Payment(s)
Charges				
6/25/2017	ALS EMERGENCY	FRANK	$950.00	
6/25/2017	MILEAGE	FRANK	$54.00	
		Charge Total:	$1,004.00	
Payments				
Paid By:	PALMETTO GBA WV	WO MANDATORY INS ADJ		($603.97)
Paid By:	PALMETTO GBA WV	PAYMENT		($318.73)
Paid By:	MILLER, FRANK	SUB - SUBSCRIBER COURTESY		($81.30)
Paid By:	MILLER, FRANK	SUB - SUBSCRIBER COURTESY		$81.30
Paid By:	MILLER, FRANK	PAYMENT		($5.00)
Paid By:	HUNTINGTON VAMC FEE BASIS	AJ MANDATORY INS ADJ		($5.00)
Paid By:	MILLER, FRANK	Refunds Patients		$5.00
Paid By:	HUNTINGTON VAMC FEE BASIS	AJ MANDATORY INS ADJ		($76.30)
Paid By:	PALMETTO GBA WV	WO MANDATORY INS ADJ		$603.97
Paid By:	HUNTINGTON VAMC FEE BASIS	PAYMENT		($1,004.00)
Paid By:	HUNTINGTON VAMC FEE BASIS	AJ MANDATORY INS ADJ		$76.30
Paid By:	PALMETTO GBA WV	WO MANDATORY INS ADJ		$2.28

BALANCE $0.00

AIR EVAC LIFETEAM

P.O. Box 106
West Plains, MO 65775

Return Service Requested

patientaccounts@amgh.us
Phone: (877) 288-5340
Fax: (417) 255-2312

Authorization to Bill

Signing this form will not increase patient financial responsibility; however, without your signature your insurance may not pay Air Evac EMS, Inc for the services provided to Frank K. Miller. This will leave $31,179.16 as patient financial responsibility.

Patient Name: Frank K. Miller

Date of Service: 06/25/2017

Policyholder/Insured: _____

Call #: 30017736420A

Assignment of Insurance Benefits; Financial Responsibility: Air Evac EMS, Inc will work for and with you in an effort to obtain proper reimbursement from your insurance plan. An assignment of benefits will assist Air Evac EMS, Inc in working with your insurance plan.

I assign all applicable health insurance benefits to which I and/or my dependents are entitled to Air Evac EMS, Inc. I certify that the health insurance information I have provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I will use my best efforts to assist with submitting insurance claims.
I authorize Air Evac EMS, Inc to submit claims, on my and/or my dependent's behalf, for payment to Medicare, Medicaid, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay Air Evac EMS, Inc directly for the services rendered to me or my dependent. To the extent that my current policy prohibits direct payment to Air Evac EMS, Inc, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Air Evac EMS, Inc upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check to me and mail it directly to Air Evac EMS, Inc.
I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to Air Evac EMS, Inc on my behalf.
I understand that I am financially responsible for the billed charges for the services provided to patient by Air Evac EMS, Inc, regardless of my insurance coverage, and in some cases may be responsible for an amount in addition to that which is paid by my insurance, such as co-pay, co-insurance, deductible and any remaining balance. I agree to immediately remit to Air Evac EMS, Inc any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Air Evac EMS, Inc.

Authorization to Release Information: Air Evac EMS, Inc may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

I authorize and direct any holder of medical information or documentation to include city, county and state accident reports about me or my dependent to release such information to Air Evac EMS, Inc, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by Air Evac EMS, Inc.

ERISA Authorization (Only Applies to Employer Sponsored Plans): ERISA is a federal law that allows a patient's Authorized Representative to handle the patient's insurance claim.

I hereby designate Air Evac EMS, Inc as my Authorized Representative under ERISA and its regulations. I hereby designate, authorize, and convey to Air Evac EMS, Inc to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have relating to such insurance policy and/or benefit plan; and (2) the right and ability to pursue any claim, right, or cause of action in connection with said insurance policy and/or benefit plan, including but not limited to any cause of action under ERISA, with respect to any healthcare expense incurred as a result of the services I or my dependent received from Air Evac EMS, Inc and, to the extent permissible under the law, to claim, such benefits, claims, or reimbursement, and any other applicable remedy, including expenses, damages, penalties or fines. To the extent that the applicable insurance policy and/or employee health care benefit plan lawfully prohibits such any of the assignments described above in this paragraph, I authorize Air Evac EMS, Inc to take the actions described in this paragraph on my behalf.

Sign, date and return this sheet

Patient Signature: _____ **Date:** _____

Representative Signature: _____ **Date:** _____

(A representative is considered to be someone other than the patient who is responsible for the patient's medical and/or financial affairs.)

A copy of this form is valid as an original.

CHARLESTON AREA MEDICAL CENTER
501 MORRIS ST
CHARLESTON WV253011326

PO BOX 37178
BALTIMORE MD 212973178

PAT CNTL #: 3778331
MED REC #: 20026241
TYPE OF BILL: 111
FED TAX NO: 550526150
STATEMENT COVERS PERIOD FROM: 06/25/2017 THROUGH: 07/03/2017

PATIENT NAME: MILLER FRANK
PATIENT ADDRESS: 9964 DANIEL BOONE PKWY, FOSTER WV 250816042

BIRTHDATE	SEX	ADMISSION DATE	HR	TYPE	SRC	DHR	STAT
04/24/1965	M	06/25/2017	22	1	1	12	01

OCCURRENCE CODE	DATE	CODE	DATE	CODE	DATE
11	06/25/2017	A1	04/24/1965	B1	04/24/1965

DEPARTMENT OF VETERAN AFFAIRS
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

VALUE CODE	AMOUNT	CODE	AMOUNT
01	1975.00	80	8.00

REV. CD.	DESCRIPTION	SERV. UNITS	TOTAL CHARGES
0120	ROOM-BOARD/SEMI	5	10280.00
0200	ICU	3	14361.00
0250	PHARMACY	104	625.76
0270	MED-SUR SUPPLIES	3	768.00
0300	LAB	76	6649.00
0301	LAB/CHEMISTRY	56	3897.00
0305	LAB/HEMATOLOGY	3	227.00
0310	PATH LAB	2	1026.00
0320	DX X-RAY	1	226.00
0324	DX X-RAY/CHEST	3	687.00
0350	CT SCAN	1	2266.00
0360	OR SERVICES	222	26862.00
0391	BLOOD/ADMIN	1	475.00
0392	PROCESSING AND STORAGE	1	384.00
0410	RESPIRATORY SVC	19	1634.00
0420	PHYSICAL THERAPY	4	511.02
0430	OCCUPATIONAL THERAPY	4	534.02
0450	EMERGENCY ROOM	1	2415.00
0636	DRUGS/DETAIL CODE	164	1257.31
0710	RECOVERY ROOM	5	415.00
0730	EKG/ECG	1	226.00
0921	PERI VASCUL LAB	2	1424.00
0001	PAGE 1 OF 1 — CREATION DATE 07/12/2017	TOTALS	77150.13

NPI: 1952380239

PAYER NAME	HEALTH PLAN ID	REL INFO	ASG BEN
DEPARTMENT OF VETERAN AFFAIRS	2845684	Y	Y
MEDICARE	2845904	Y	Y

INSURED'S NAME		P REL	INSURED'S UNIQUE ID	GROUP NAME
MILLER	FRANK	18	1051452026	UNKNOWN
MILLER	FRANK	18	234172578A	MEDICARE

TREATMENT AUTHORIZATION CODES / DOCUMENT CONTROL NUMBER / EMPLOYER NAME

Diagnosis codes: S36898A Y, E872 Y, D62 Y, S71102A Y, S81802A Y, I10 Y, K589 Y, E119 Y, K219 Y, Z720, F4310 Y, I252

ADMIT DX: S36898A
PPS CODE: 0908
ECI: W320XXA

PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
0WJG0ZZ	06/26/2017	0WJH0ZZ	06/26/2017	0WJP0ZZ	06/26/2017
0DTL0ZZ	06/26/2017	0DTA0ZZ	06/26/2017		

ATTENDING NPI 1407942345 LAST DELUCA FIRST JOHN
OPERATING NPI 1407942345 LAST DELUCA FIRST JOHN

REMARKS
B3 282N00000X

DEPARTMENT OF VETERAN AFF
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA CHAM 0026778008

1 MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							1051452026		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
MILLER	FRANK		04/24/1965	M [X] F [ ]	MILLER	FRANK			
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)				
9964 DANIEL BOONE PKWY			Self [X] Spouse [ ] Child [ ] Other [ ]		9964 DANIEL BOONE PKWY				
CITY		STATE	8. RESERVED FOR NUCC USE		CITY		STATE		
FOSTER		WV			FOSTER		WV		
ZIP CODE	TELEPHONE (Include Area Code)				ZIP CODE	TELEPHONE (Include Area Code)			
250816042	( )				250816042	( )			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER				
MILLER	FRANK								
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH MM DD YY		SEX		
234172578A			[ ] YES [X] NO		04/24/1965		M [X] F [ ]		
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)				
			[ ] YES [X] NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME				
			[ ] YES [X] NO		DEPARTMENT OF VETERAN AFF				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
MEDICARE					[ ] YES [X] NO If yes, return to and complete Item 9a-d				

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE MM DD YY QUAL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06/25/2017 TO			
DN DELUCA JOHN			17b NPI 1407942345						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0						22. RESUBMISSION CODE 7 ORIGINAL REF. NO.			
A. S31104A	B. S71102A	C. S81802A	D. W320XXA			23. PRIOR AUTHORIZATION NUMBER			
E.	F.	G.	H.						
I.	J.	K.	L.						

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL.	J. RENDERING PROVIDER ID #
1 PHY-ED EVALUATION LVL 5 06/25/2017	06/25/2017	23		99285	25	ABCD	429.00	1		NPI	1407942345
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
550526150	[ ]	[X]	3930594	[X] YES [ ] NO	$ 429 00	$	429 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JOHN DELUCA 07/31/2017
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
GENERAL HOSPITAL
501 MORRIS STREET
CHARLESTON WV 253011326
a. 1952390239 b.

33. BILLING PROVIDER INFO & PH# (3048687530
CHARLESTON AREA MEDICAL
PO BOX 37178
BALTIMORE MD 212973178
a. 1124248752 b.

DEPARTMENT OF VETERAN AFF
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA CHAM 0026778009

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
							1051452028	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MILLER FRANK	04/24/1965 M [X] F [ ]	MILLER FRANK
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9864 DANIEL BOONE PKWY	Self [X] Spouse [ ] Child [ ] Other [ ]	9964 DANIEL BOONE PKWY
CITY: FOSTER STATE: WV	8. RESERVED FOR NUCC USE	CITY: FOSTER STATE: WV
ZIP CODE: 250816042 TELEPHONE (Include Area Code): ( )		ZIP CODE: 250816042 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MILLER FRANK	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 234172578A	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY: 04/24/1965 SEX: M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: DEPARTMENT OF VETERAN AFF
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN) DELUCA JOHN	17a [ ] 17b NPI 1407942345	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06/25/2017 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S36898A B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE: 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL	J. RENDERING PROVIDER ID #
1 INTRAPER PROC IN UPPER ABDOMEN (CRNA) 06/25/2017	06/25/2017	21		00790	QX	A	2106.00	232		NPI	1679808539
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
550528150	[ ]	[X]	3930600	[X] YES [ ] NO	$ 2106 00	$	2106 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (3043887530
ANGELA HAYNES 07/31/2017 SIGNED DATE	GENERAL HOSPITAL 501 MORRIS STREET CHARLESTON WV 253011326 a. 1952390239 b.	CHARLESTON AREA MEDICAL PO BOX 37178 BALTIMORE MD 212973178 a. 1124248752 b.

DEPARTMENT OF VETERAN AFF
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA CHAM 0026778045 PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID/DoD #) (Member ID#) (ID#) (ID#) (ID#)	1051452026

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MILLER FRANK	04/24/1965 M [X] F [ ]	MILLER FRANK
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9964 DANIEL BOONE PKWY	Self [X] Spouse [ ] Child [ ] Other [ ]	9964 DANIEL BOONE PKWY
CITY: FOSTER STATE: WV	8. RESERVED FOR NUCC USE	CITY: FOSTER STATE: WV
ZIP CODE: 250816042 TELEPHONE (Include Area Code): ( )		ZIP CODE: 250816042 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MILLER FRANK	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 234172578A	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: 04/24/1965 SEX: M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: DEPARTMENT OF VETERAN AFF
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN DELUCA JOHN	17a. [ ] 17b. NPI 1407942345	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06/25/2017 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0

A. S36898A	B. E872	C. D62	D. S71102A
E. S81802A	F. I10	G. K589	H. E119
I. K219	J. Z720	K. F4310	L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 51D0234333

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL.	J. RENDERING PROVIDER ID #
1 88307 AP BILL GROSS AND MICRO LEVEL V PATHOLOGY 06/26/2017	06/26/2017	21		88307	26	ABC	585.00	1		NPI	1588626444
2 88307 AP BILL GROSS AND MICRO LEVEL V PATHOLOGY 06/26/2017	06/26/2017	21		88307	26	ABC	585.00	1		NPI	1588626444
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
550526180 [ ] [X]	3930586	[X] YES [ ] NO	$ 1170 00	$	1170 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (304)8887530
TZONG-WEN HUANG 07/31/2017 SIGNED DATE	GENERAL HOSPITAL 501 MORRIS STREET CHARLESTON WV 253011326	CHARLESTON AREA MEDICAL PO BOX 37178 BALTIMORE MD 212973178
	a. 1952390239 b.	a. 1124248752 b.

DEPARTMENT OF VETERAN AFF
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA CHAM 0026778046

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (ID/DoD #) (Member ID#) (ID#) (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
1051452026		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MILLER FRANK	04/24/1965 M X F	MILLER FRANK
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9964 DANIEL BOONE PKWY	Self X Spouse Child Other	9964 DANIEL BOONE PKWY
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
FOSTER WV		FOSTER WV
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
250816042 ( )		250816042 ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
MILLER FRANK		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH SEX
234172578A		04/24/1965 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		DEPARTMENT OF VETERAN AFF
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d
MEDICARE		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
DN DELUCA JOHN	17b NPI 1407942345	FROM 06/25/2017 TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S36898A	B. E872	C. D62	D. S71102A
E. S81802A	F. I10	G. K589	H. E119
I. K219	J. Z720	K. F4310	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL.	J. RENDERING PROVIDER ID #
1 CV ECG REPORT 06/26/2017	06/26/2017	21		93010		ABC	34.00	1		NPI	1689771149
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
550526150 X	3930598	X YES NO	$ 34 00	$	34 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MITCHELL RASHID 07/31/2017
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
GENERAL HOSPITAL
501 MORRIS STREET
CHARLESTON WV 253011328
a. 1952390239 b.

33. BILLING PROVIDER INFO & PH # (3043883530
CHARLESTON AREA MEDICAL
PO BOX 37178
BALTIMORE MD 212973178
a. 1124248752 b.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

DEPARTMENT OF VETERAN AFF
1201 BROAD ROCK BOULEVARD
RICHMOND VA 23249

PICA CHAM 0026778047

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1051452026
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MILLER FRANK	3. PATIENT'S BIRTH DATE MM DD YY 04/24/1965	SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) MILLER FRANK	
5. PATIENT'S ADDRESS (No., Street) 9984 DANIEL BOONE PKWY	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street) 9984 DANIEL BOONE PKWY	
CITY FOSTER	STATE WV	8. RESERVED FOR NUCC USE	CITY FOSTER	STATE WV
ZIP CODE 250816042	TELEPHONE (Include Area Code) ( )		ZIP CODE 250816042	TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) MILLER FRANK		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 234172578A		a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY 04/24/1965	SEX M [X] F [ ]
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME DEPARTMENT OF VETERAN AFF	
d. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE		10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN DELUCA JOHN	17a. [ ] 17b. NPI 1407942345	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06/25/2017 TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ]	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0

A. S36898A	B. E872	C. D62	D. S71102A
E. S81802A	F. I10	G. K589	H. E119
I. K219	J. Z720	K. F4310	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL.	J. RENDERING PROVIDER ID #
1 CV VAS ARTERIAL W ABI LOWER LEFT 06/26/2017	06/26/2017	21		93926		ABC	55.00	1		NPI	1699867598
2 CV VAS ARTERIAL W ABI LOWER LEFT 93922 PROFESSIONAL 06/26/2017	06/26/2017	21		93922		ABC	28.00	1		NPI	1699867598
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 550526150 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. 3930599	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 83.00	29. AMOUNT PAID $	30. Rsvd for NUCC Use 83.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) ALI ABURAHMA 07/31/2017 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION GENERAL HOSPITAL 501 MORRIS STREET CHARLESTON WV 253011326 a. 1952380239 b.		33. BILLING PROVIDER INFO & PH# (3043883530 CHARLESTON AREA MEDICAL PO BOX 37178 BALTIMORE MD 212873178 a. 1124248752 b.		

CHARLESTON AREA MEDICAL CENTER
501 MORRIS ST
CHARLESTON WV253011326

PO BOX 37178
BALTIMORE MD 212973178

PAT CNTL # 3843718
MED REC # 10707678
TYPE OF BILL 131
FED TAX NO 550526150
STATEMENT COVERS PERIOD FROM 07/12/2017 THROUGH 07/12/2017

PATIENT NAME: MILLER FRANK
PATIENT ADDRESS: 9964 DANIEL BOONE PKWY, FOSTER WV 250816042

BIRTHDATE	SEX	ADMISSION DATE	HR	TYPE	SRC	CONDITION CODES
04/24/1965	M			3	1	01 10 11

OCCURRENCE CODE	DATE	OCCURRENCE CODE	DATE
05	06/25/2017	18	01/01/2013

FRANK MILLER
9964 DANIEL BOONE PKWY

FOSTER WV 250816042

VALUE CODE	AMOUNT
45	14.00

REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES
0510	OFFICE VISIT LEVEL 2 EST 99212	G0463	07/12/2017	1	109.00	
0001	PAGE 1 OF 1	CREATION DATE	07/20/2017	TOTALS	109.00	

PAYER NAME	HEALTH PLAN ID	REL INFO	ASG BEN	PRIOR PAYMENTS	EST. AMOUNT DUE
MEDICARE	2845904	Y	Y		
VA MEDICAL CENTER	2846180	Y	Y		

NPI 1952390239

INSURED'S NAME		P. REL	INSURED'S UNIQUE ID	GROUP NAME	INSURANCE GROUP NO.
MILLER	FRANK	18	234172578A		
MILLER	FRANK	18	1051452026	UNKNOWN	

TREATMENT AUTHORIZATION CODES | DOCUMENT CONTROL NUMBER | EMPLOYER NAME

DX: S31109A

0

ATTENDING NPI 1306932140 LAST LUCENTE FIRST FRANK

OPERATING NPI

OTHER NPI

REMARKS

CC a B3 282N00000X

1 CHARLESTON AREA MEDICAL CENTER 501 MORRIS ST CHARLESTON WV253011326	2 PO BOX 37178 BALTIMORE MD 212973178	3a PAT CNTL # 4348683 b MED REC # 10707878 4 TYPE OF BILL 131 5 FED TAX NO 550526150 6 STATEMENT COVERS PERIOD FROM 07/19/2017 THROUGH 07/19/2017

8 PATIENT NAME: MILLER FRANK	9 PATIENT ADDRESS: 9964 DANIEL BOONE PKWY, FOSTER WV 250816042

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	17 STAT
04/24/1966	M			3	1	01

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE
11	06/25/2017	18	01/01/2013

38: FRANK MILLER
9964 DANIEL BOONE PKWY
FOSTER WV 250816042

39 VALUE CODES CODE	AMOUNT
45	20.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0510	OFFICE VISIT LEVEL 2 EST 99212	G0463	07/19/2017	1	109.00	
0001	PAGE 1 OF 1	CREATION DATE	09/22/2017	TOTALS	109.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE	2845904	Y	Y			1952390239
VA MEDICAL CENTER	2846180	Y	Y			

58 INSURED'S NAME		59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
MILLER	FRANK	18	234172578A		
MILLER	FRANK	18	1051452026	UNKNOWN	

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: Z09
0

69 ADMIT DX / 70 PATIENT REASON DX / 72 ECI

74 PRINCIPAL PROCEDURE CODE DATE / a. OTHER PROCEDURE CODE DATE / b. OTHER PROCEDURE CODE DATE / c. OTHER PROCEDURE CODE DATE / d. OTHER PROCEDURE CODE DATE / e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1457427395 QUAL
LAST WARDEN FIRST GLENN
77 OPERATING NPI QUAL
LAST FIRST

80 REMARKS
81CC a B3 282N00000X

78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

WVU Medicine at Charleston Area Medical Center

Guarantor Number:	101311949
Guarantor Name:	FRANK MILLER
Statement Date:	08/05/17
Current Balance Due Upon Receipt:	7839.00

Thank you for selecting WVU Medicine at CAMC for your healthcare needs. Please submit payment upon receipt to "WVU Physicians of Charleston." To make payment by phone or to discuss payment arrangements, please call 1-800-314-1219.

PATIENT NAME DATE	DESCRIPTION	CHARGES/ ADJUSTMENTS	TOTAL
FRANK MILLER 6/26/2017	PART REMOVAL COLON W ANASTOMOSIS	3,918.00	3,918.00
FRANK MILLER 6/26/2017	MOBILIZE SPLENIC FLEX	354.00	354.00
FRANK MILLER 6/26/2017	RESECT SMALL INTEST,SINGL RESEC/ANAS	3,567.00	3,567.00

Total Account Balance	$7839.00
Insurance Pending	$0.00
Amount Due	**$7839.00**

#-Contested Charge *-New Charge

MyWVUChart is a free, easy and secur way to view your health information.

- ✓ Communicate with your healthcare providers
- ✓ Manage your appointments
- ✓ Request prescription refills
- ✓ View test results
- ✓ View and pay your bill online

Don't have a MyChart account?
Go to www.mywvuchart.com and use the activation code below to get started

Also available on MyChart mobile

Available on the App Store | GET IT ON Google play

This is an attempt to collect a debt. Any information obtained will be used for that purpose.

PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT

WVU Medicine at Charleston Area Medical Center

PO BOX 7000
MORGANTOWN, WV 26507-7000
ADDRESS SERVICE REQUESTED

Due Date UPON RECEIPT	☐ MC	Guarantor # 101311949	Statement Date 08/05/17
Amount Due 7839.00	☐ DISCOVER	Card #	Exp Date Sec Code
Amount Enclosed $	☐ VISA	Signature	Check #

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

MAKE CHECK PAYABLE AND REMIT TO 114491-SA51-211

FRANK MILLER
9964 DANIEL BOONE PKWY
FOSTER WV 25081-6042

WVU PHYSICIANS OF CHARLESTON
PO BOX 7000
MORGANTOWN, WV 26507-7000

010131194900000000000007839002

023078

GENERAL ANESTHESIA SERVICES, INC.

Go Green
Pay Online | Update Info
www.ezmedinfo.com/gas1

Summary of Service Charges

DATE	PROC CODE	UNITS	DETAILS OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
Patient: FRANK MILLER					Referred By: JOHN A. DELUCA Services Were Provided at: CAMC GENERAL HOSPITAL IP		
06-25-17	**44120**	**24**	**REMOVAL OF SMALL INTESTINE**	**2040.00**	**1936.10**	**DENIAL**	**103.90**
06-29-17			FILED PRIMARY TO VA MEDICAL CENTER ORLANDO (VA028)				
07-07-17			FILED SECONDARY TO MEDICARE				
07-21-17			MEDICARE PAYMENT		139.96		
07-21-17			MEDICARE NON ALLOWED		1796.14		
07-21-17			GUARANTOR RESPONSIBILITY DATE (CHARGEID: 2318386)				
06-25-17	**36620**	**1**	**INSERTION CATHETER ARTERY**	**225.00**	**214.48**	**DENIAL**	**10.52**
06-29-17			FILED PRIMARY TO VA MEDICAL CENTER ORLANDO (VA028)				
07-07-17			FILED SECONDARY TO MEDICARE				
07-21-17			MEDICARE PAYMENT		41.23		
07-21-17			MEDICARE NON ALLOWED		173.25		
07-21-17			GUARANTOR RESPONSIBILITY DATE (CHARGEID: 2318387)				

The insurance carrier noted above denied payment of your claim and indicated that the amount due is now your responsibility. If you have questions about your benefits or your EOB please call your insurance company. Total amount is due immediately. Please contact us to make payment arrangements.

Current	31-60 Days	61-90 Days	Over 90 Days
$114.42	$0.00	$0.00	$0.00

WE HAVE FILED YOUR INSURANCE. YOU ARE NOW RESPONSIBLE FOR THE BALANCE OF THIS ACCOUNT.

DATE DUE:	BALANCE DUE:
Upon Receipt	$114.42

GENERAL ANESTHESIA SERVICES, INC.
PO BOX 3193
INDIANAPOLIS, IN 46206-3193
1.844.898.7951

If your insurance has issued payment directly to you, please send us this payment immediately to stop the collection efforts.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

Patient Statement For: FRANK MILLER

Statement Date
07/25/17

Account Number
497725-QGAS1

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

ASSOCIATED RADIOLOGISTS, INC.
P O BOX 11137
CHARLESTON, WV 25339-1137

TEMP-RETURN SERVICE REQUESTED

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
09-06-17	**22.88**	327430-QARI1

RESPONSIBLE PARTY
FRANK K MILLER

INVOICE: 2070357

SHOW AMOUNT PAID HERE $

ADDRESSEE:

FRANK K MILLER
9964 DANIEL BOONE PK
FOSTER, WV 25081-6042
00801

MAKE CHECKS PAYABLE TO:

ASSOCIATED RADIOLOGISTS, INC.
P O BOX 11137
CHARLESTON, WV 25339-1137

To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

For your convenience, if your personal check is dishonored or returned for NSF or uncollected funds, we will electronically debit your account for the amount of the check. A state allowable processing fee will be charged to you separately.

DATE	OPT-MOD	DR	SERVICE	LOC	INSURANCE COMPANY	AMOUNT	PAID BY INS	ADJUST	YOU PAID	YOU OWE
CHARGES FOR PATIENT: FRANK MILLER (327430-QARI1)										
06-25-17	71010-26	21	CHEST PA, 1V	CAMC GEN	PALMETTO	40.00	7.10	31.09		1.8
06-25-17	72100-26	21	LUMBAR SPINE 2-3V	CAMC GEN	PALMETTO	51.00	8.69	40.09		2.2
06-25-17	73706-26	21	CTA LWR EXTREM W-W/O,	CAMC GEN	PALMETTO	425.00	73.89	332.26		18.8
ADDITIONAL INFORMATION CONCERNING YOUR ACCOUNT										
PLEASE CONTACT OUR OFFICE IF YOU NEED TO MAKE PAYMENT ARRANGEMENTS.										
RENDERING PROVIDER 21 IS CHRIS SCHLARB MD										
ADDITIONAL STATEMENT MESSAGE										
TOTALS:						516.00	89.68	403.44	0.00	22.8

STATEMENT DATE	RESPONSIBLE PARTY	ACCOUNT #	PAY THIS AMOUNT
09-06-2017	FRANK K MILLER	327430-QARI1	22.88

PAYMENTS RECEIVED AFTER THIS STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT. PAYMENT DUE UPON RECEIPT. THANK YOU.

DAYS	0 - 30	31 - 60	61 - 90	91 - 120	Over 120
ACCOUNT AGING	22.88	0.00	0.00	0.00	0.00

MAKE CHECK PAYABLE TO:
ASSOCIATED RADIOLOGISTS, INC.

To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari

INVOICE #: 2070357

FOR BILLING QUESTIONS CALL (304) 344-3457

AW

ASSOCIATED RADIOLOGISTS, INC.
P O BOX 11137
CHARLESTON, WV 25339-1137

TEMP-RETURN SERVICE REQUESTED

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
08-02-17	**17.92**	327430-QARI1

RESPONSIBLE PARTY
FRANK K MILLER

INVOICE: 2056416

SHOW AMOUNT PAID HERE $

ADDRESSEE:

FRANK K MILLER
9964 DANIEL BOONE PK
FOSTER, WV 25081-6042
00526

MAKE CHECKS PAYABLE TO:

ASSOCIATED RADIOLOGISTS, INC.
P O BOX 11137
CHARLESTON, WV 25339-1137

To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

For your convenience, if your personal check is dishonored or returned for NSF or uncollected funds, we will electronically debit your account for the amount of the check. A state allowable processing fee will be charged to you separately.

DATE	OPT-MOD	DR	SERVICE	LOC	INSURANCE COMPANY	AMOUNT	PAID BY INS	ADJUST	YOU PAID	YOU OWE
CHARGES FOR PATIENT: FRANK MILLER (327430-QARI1)										
06-27-17	71010-26	32	CHEST PA, 1V	CAMC GEN	PALMETTO	40.00		30.95		9.0
06-30-17	71010-26	39	CHEST PA, 1V	CAMC GEN	PALMETTO	40.00		31.13		8.8
ADDITIONAL INFORMATION CONCERNING YOUR ACCOUNT										
			PLEASE CONTACT OUR OFFICE IF YOU NEED TO MAKE PAYMENT ARRANGEMENTS.							
			RENDERING PROVIDER 32 IS RUSSELL KING II MD							
			RENDERING PROVIDER 39 IS MATTHEW MORRIS							
ADDITIONAL STATEMENT MESSAGE										
TOTALS:						80.00	0.00	62.08	0.00	17.9

STATEMENT DATE	RESPONSIBLE PARTY	ACCOUNT #	PAY THIS AMOUNT
08-02-2017	FRANK K MILLER	327430-QARI1	17.92

PAYMENTS RECEIVED AFTER THIS STATEMENT DATE WILL APPEAR ON YOUR NEXT STATEMENT. PAYMENT DUE UPON RECEIPT. THANK YOU.

DAYS	0-30	31-60	61-90	91-120	Over 120
ACCOUNT AGING	17.92	0.00	0.00	0.00	0.00

MAKE CHECK PAYABLE TO:
ASSOCIATED RADIOLOGISTS, INC.

To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari

INVOICE #: 2056416

FOR BILLING QUESTIONS CALL (304) 344-3457

AW

BOONE MEMORIAL HOSPITAL INC
PO BOX 11407
BIRMINGHAM AL 35246-0949

ADDRESS SERVICE REQUESTED

003702
0101

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW:

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA ☐ OTHER

CARD NUMBER	SIGNATURE CODE	EXP. DATE

SIGNATURE	ZIP CODE

PATIENT NAME	ACCT. #
MILLER FRANK K	523301

STATEMENT DATE	PRINT DATE	AMOUNT DUE	AMOUNT PAID
04/30/18	05/09/18	4177.00	

TELEPHONE NO.
866-888-0870

PAYMENTS AND CHARGES RECEIVED AFTER DATE ON THIS STATEMENT WILL BE REFLECTED ON THE NEXT STATEMENT.

GUARANTOR NAME AND ADDRESS

MILLER FRANK K
9964 DANIEL BOONE PKWY
FOSTER, WV 25081-6042

BOONE MEMORIAL HOSPITAL INC
PO BOX 11407
BIRMINGHAM, AL 35246-0949

TO INSURE CREDIT TO YOUR ACCOUNT, PLEASE RETURN THIS STUB WITH YOUR PAYMENT.

STATEMENT OF ACCOUNT

606144 (PC1)

PATIENT NAME	ACCOUNT NUMBER	PATIENT TYPE	SERVICE BEGIN	SERVICE END
MILLER FRANK K	523301	O/P	12/13/17	00/00/00

INSURANCE COMPANY NAME	ANTICIPATED AMOUNT	AMOUNT PAID	CLAIM STATUS
TRI WEST -REC		1232.00	PAID ON 03/02/18
TRI WEST -REC			INS CO R03/12/18
TRI WEST -REC	3368.00		PAYMENT PENDING
TRI WEST -REC	1736.00		PAYMENT PENDING
TRI WEST -REC	2848.00		PAYMENT PENDING

TOTAL CHARGES	INSURANCE COVERAGE	PATIENT PORTION	PAID BY PATIENT	LATE CHARGE	DUE FROM PATIENT
13361.00	9184.00	4177.00	0.00		4177.00

COMMENTS

YOUR INSURANCE HAS PAID. PLEASE REMIT
BALANCE DUE.*866-888-0870*
CREDIT CARDS ACCEPTED*
*

Visit www.bmh.org for our Financial Assistance Policy and Application

HOSPITAL NAME

BOONE MEMORIAL HOSPITAL INC

RETAIN THIS COPY FOR YOUR RECORDS

8485

381493-TBSTMT-410015-267821658-P; 1120797-1-415; 39508177-1; 1

Patient Transaction Report

Neurology And Headache Clinic Pllc

Provider: All **Date Range:** Sep 3, 2018-Apr 19, 2019

PATIENT NAME: MILLER, FRANK K **ACCOUNT #:** 113731 **DOB:** Apr 24, 1965

Appointment Provider Name	CLAIM NO	DATE	CODE/DESC	BALANCE
DAVE, DARSHAN	18271	Nov 26, 2018	99204 Office Visit, New Pt., Level 4	$267.70
		Mar 22, 2019	TRICARE FOR LIFE Contractual	($108.25)
		Mar 22, 2019	TRICARE FOR LIFE Payment	($159.45)
CLAIM BALANCE				**$0.00**
DAVE, DARSHAN	18277	Nov 26, 2018	95886 MUSC TEST DONE WN TEST COMP	$330.00
		Nov 26, 2018	95913 NRV CNDJ TEST 13 STUDIES	$755.00
		Feb 26, 2019	TRICARE Contractual	($626.88)
		Feb 26, 2019	TRICARE Payment	($458.12)
CLAIM BALANCE				**$0.00**
ACCOUNT SUMMARY				**$0.00**
Charge				$1,352.70
Contractual				($735.13)
Payment				($617.57)
Total Balance				**$0.00**

MedCare Therapy Center LLC
3/11/2019 9:38:11 AM
Patient Ledger View
FRANK MILLER
Account #: 3407969
FRANK MILLER

#	DOS	Charges	InsPay	PatPay	InsAdjAmt	PatAdjAmt	PatBal	InsBal	Bal	Ins	POS	EOB	Case_Id
1	01/18/2019	$220.00	$133.52	$0.00	$86.48	$0.00	$0.00	$0.00	$0.00	HUNTINGTON VA CENTER	OFFIC	EOB Info	9332274
2	01/23/2019	$100.00	$59.68	$0.00	$40.32	$0.00	$0.00	$0.00	$0.00	HUNTINGTON VA CENTER	OFFIC	EOB Info	9332274
3	01/25/2019	$100.00	$59.68	$0.00	$40.32	$0.00	$0.00	$0.00	$0.00	HUNTINGTON VA CENTER	OFFIC	EOB Info	9332274
4	01/28/2019	$100.00	$59.68	$0.00	$40.32	$0.00	$0.00	$0.00	$0.00	HUNTINGTON VA CENTER	OFFIC	EOB Info	9332274
5	01/30/2019	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.00	$100.00	HUNTINGTON VA CENTER	OFFIC		9332274
6	02/04/2019	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.00	$100.00	HUNTINGTON VA CENTER	OFFIC		9332274
7	02/06/2019	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.00	$100.00	HUNTINGTON VA CENTER	OFFIC		9332274
8	02/11/2019	$150.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.00	$150.00	HUNTINGTON VA CENTER	OFFIC		9332274
		$970.00	$312.56	$0.00	$207.44	$0.00	$0.00	$450.00	$450.00				